Washington State Department of Social & Health Services

Dennis Braddock, Secretary

2001-03 Medical Financing

July-August 2002

Medicaid Reform in Washington State

The search for more flexibility and better management tools to deal with rising costs

Town Hall Schedule

During May and June, Medical Assistance Administration teams met with stakeholders, clients, health-care providers and others to comment on the proposed amended waiver at the dates and times listed:

May 21, Spokane
6 to 9 p.m.
Sacred Heart Medical Center

May 22, Olympia
6 to 9 p.m.
Town Square Complex
Plum and Union, Building 2,
First Floor Training Room

May 28, Tacoma
6 to 9 p.m.
South Park Community Center
Conference Center (First Floor)

May 30, Bellingham
6 to 9 p.m.
Garden Street Family Center
Conference Room

June 5, Port Angeles
6 to 9 p.m.
Vern Burton Center

June 6, Seattle/Everett
6 to 9 p.m.
Shoreline Community College

June 11, Tri-Cities
6 to 9 p.m.
Columbia Basin College

June 12, Yakima
6 to 9 p.m.
Epic Center

June 18, Vancouver
6 to 9 p.m.
Educational Service District 112

June 20, Seattle/Des Moines
6 to 9 p.m.
Highline Community College

Reports on each of the Town Meetings were posted on the Medicaid Reform web site. Washington residents can still comment on the proposals by e-mail, by leaving comments on the Web site, or by mailing written testimony to:

Medical Assistance Administration
ATTN: Medicaid Waiver/Rich Pannkuk
P.O. Box 45500, Olympia, WA 98504

Or send comments via e-mail to:
pannkre@dshs.wa.gov

WHY REFORM? Washington State has been a national leader in providing health care to its children, vulnerable adults, and the working poor for decades. In a time of lower health care costs and more state funding, the state was able to expand coverage. But now health costs are increasing significantly, and the demand for coverage and services continues to grow. State funding sources are not able to keep pace. The Department of Social and Health Services (DSHS) provides medical assistance to more than 900,000 Washington residents each month, and the weight of those costs has reached a budgetary milestone – rising now at the rate of a half billion dollars a year. Although Medicaid programs today consume more than 40 percent of the total DSHS budget, reimbursement levels are leading some providers to limit their Medicaid caseload.

The Background

In the fall of 2001, Medical Assistance Administration (MAA) unveiled its first draft of a 1115 Demonstration Waiver aimed at giving the state new flexibility in dealing with its health care expenditures. But in subsequent meetings with stakeholders, clients, legislators and the federal Centers for Medicare and Medicaid Services (CMS), it became clear that the initial proposal needed revision. Critics who felt the waiver proposal went too far and those who felt it did not go far enough agreed on one thing: MAA needed to be much more specific about the circumstances in which it would use its requested flexibility. So in May and June, MAA went back to the drawing board, holding a series of Town Meetings around the state to solicit feedback on the waiver. Participants opposed benefit reductions in general, but were more supportive of cutting adult dental, hearing and vision coverage than making changes in children's coverage. The meetings also helped clarify access issues around a proposed co-payment on non-emergency visits to hospital emergency rooms. And while many participants objected in principle to the idea of an enrollment freeze and premiums, there was also agreement that any premiums should be as small as possible and remain symbolic, not simply a revenue source.

The Amended Waiver

The new waiver draft was posted on the Web on July 22 and distributed to interested parties for additional feedback and public comment. The comment period will close at 5 p.m. on August 5. MAA plans to submit the final draft to CMS in August. The original waiver was submitted as a 1115 Demonstration Waiver. At the suggestion of CMS, the amended waiver will be submitted as a Health Insurance Flexibility and Accountability (HIFA) demonstration.

Washington: The Bellwether State

Children

The Legislature authorized three major expansions of health coverage for low-income children during the past decade. As a result, enrollment in children's Medicaid programs increased 12.5 percent per year between 1996 and 2001. It is projected to increase another 7.5 percent during the next two years.

Pregnant Women

The Medicaid-financed First Steps program was implemented in 1989 to provide health-care coverage to pregnant women and infants in households up to 185 percent of the federal poverty level. Currently, Washington's Medicaid program covers two in every five births in the state. In addition, Washington State Medicaid funds are targeting a reduction in unintended pregnancies by offering free family planning and education services to low-income residents.

Seniors

Many low-income seniors have sought Medicaid coverage to offset the growth in health-care costs, especially prescription drugs and medical equipment. (Neither of these is covered by Medicare.) Monthly per capita expenditures for prescription drugs for low-income seniors jumped from $118 in fiscal 1996 to $172 in fiscal 2001 – an annual increase of about 9 percent. As a result, DSHS caseloads for the elderly increased 12 percent a year between 1996 and 2001. The trend is expected to continue in the current biennium.

NOTE: The waiver proposal for Washington does not affect Medicaid's Long-Term Care benefits, which rank among its highest costs.

Questions About the Waiver?

Check out the web page:
http://maa.dshs.wa.gov/medwaiver

FOR MORE INFORMATION:
Jim Stevenson, PIO
360-902-7604
stevejh2@dshs.wa.gov

Persons with disabilities or special needs may call **360-902-7604** or e-mail stevejhs2@dshs.wa.gov and request a hard copy.

Keys to the Waiver

An Enrollment Freeze

Under the amended waiver, the state would set trigger points based on the periodic caseload forecasts conducted for state government. When trends reached those trigger points – indicating that expenditures were now exceeding program forecasts -- MAA would freeze enrollment in specified optional programs but continue coverage for residents already enrolled. New applicants for those optional programs would have to wait until the freeze was lifted before they could enroll in the programs and receive coverage. The freeze would not apply to mandatory Medicaid programs.

Cost Sharing

Clients in certain optional adult and children's programs whose family income totals more than the Federal Poverty Level (FPL) would have to share the cost of their coverage with small premiums. The premiums would be set at $10 for people with income between 100 percent and 150 percent of FPL; at $15 for people with income between 150 and 200 percent of FPL; and at $20 for families with incomes above 200 percent of FPL. Clients in these optional groups with incomes below 100 percent of the Federal Poverty Level would be exempt from premiums. There would be a three-person family maximum in each range: $30, $45, and $60.

Co-Payments

To provide incentives for appropriate use of medical services, all MAA clients would face the prospect of co-payments in two selective circumstances:

- Clients who insist on more expensive, brand-name drugs would have to pay a $5 co-payment per prescription when there is a lower-cost generic or therapeutic equivalent preferred drug that their doctor has approved. The co-pay would not apply if the brand-name drug were medically necessary or if there were no equivalent drug, as is currently the case with anti-depression drugs.
- Clients who visit emergency rooms for non-emergent reasons and who could have visited a primary care provider would have to pay a $10 co-payment. MAA has proposed establishing a 24-hour Medicaid consulting nurse hot line to help sort out non-emergency cases and access problems.

Benefit Redesign

Under the waiver, Medicaid would be allowed to redraft the benefit package for adults in certain optional programs to eliminate vision, hearing and non-emergency dental coverage, bringing them more in line with Basic Health benefits. All children would continue to receive full-scope Medicaid coverage.

Full Use of Currently Unspent Federal Funds

The amended waiver also would let DSHS and the Health Care Authority (HCA) use unspent federal funds from the State Children's Health Insurance Program (SCHIP) to complement other medical assistance needs. These funds (about $150 million over five years) would permit covering parents of Medicaid children enrolled in the Basic Health program or other BH adults. Federal law prohibits spending the money on other low-income children's programs, and under current rules, Washington must simply return the unspent funds, which then go to other states with higher uninsured children rates.

Tribal Exemption

The amended waiver includes a request that American Indians and Alaska Natives be exempted from co-payment and premium requirements. This provision would comport with federal trust responsibility to provide health care.

Budget neutrality

The waiver would not cover any new eligibility groups or services that are not otherwise permitted under the Medicaid State Plan. SCHIP expenditures would not be greater than the state's cumulative allotment and any reallocated SCHIP funds.

Premiums and Co-Pays: The Basic Health Model

The idea of subsidized health insurance for the poor is not new. Washington State's Basic Health program was a pioneer effort to provide affordable family health care when it was created in 1988.

Throughout its history, Basic Health has expected beneficiaries of the program to participate in the cost of their medical coverage and treatment. That contribution is minimal at the very lowest incomes – as low as $10 a month – but increases substantially toward the top of the eligibility limits – 200 percent or more of the Federal Poverty Level (FPL).

Washington's SCHIP, Health Care for Workers with Disabilities (HWD) and Transitional Medical Assistance (TMA) programs already have premium requirements that would be affected by premium policies under the waiver.

Medicaid reform proposes to apply this principle to other Medical Assistance programs. Under the waiver, some Medicaid clients with incomes above the poverty level would pay a reasonable premium to help with the expense of their medical assistance. No clients below FPL would have to pay premiums.

An Anticipated Timeline for Medicaid Reform

- **November 2001:** The initial proposed demonstration waiver was submitted in early November to the federal Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration, or HCFA).
- **January-April 2002:** Discussion of the waiver occurred during the 2002 Legislative Session and between MAA and federal officials with CMS
- **April 2002:** Assistant Secretary Doug Porter decided the state will redraft the proposal and resubmit it to CMS.
- **May-June 2002:** A series of Town Meetings was held throughout the state to give stakeholders, legislators, clients, and the public a chance to comment on the plan.
- **July 2002:** Amended waiver draft written, posted and distributed to stakeholders. A new comment period extends to August 5, 2002.
- **August 2002:** Final version of amended waiver to be submitted to CMS.
- **December 2002:** Anticipated approval of amended waiver by CMS
- **January 2003:** Legislature convenes to pass budget, review waiver provisions, and pass any necessary legislation.
- **July 2003:** Implement Medicaid reforms under approved waiver.

Goals of Medicaid Reform

- Ensure that the most vulnerable populations retain access to full-scope Medicaid coverage
- Demonstrate how more flexibility can allow the state to avoid reducing existing coverage.
- Adopt cost-sharing, benefit changes and enrollment freezes to protect current enrollees.
- Use the state's unspent State Children's Health Insurance Program (SCHIP) funds to expand Basic Health coverage for additional low-income adults.

Consequences of Not Receiving Waiver Approval

When projected program costs exceed revenue forecasts, the state has few options:

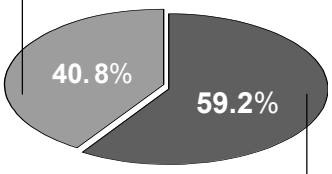
- Increase Medicaid program funding with new funding sources
- Reduce payments to providers
- Eliminate entire programs or eliminate services

The Medicaid-SCHIP Reform Waiver

Medicaid is divided between the Mandatory eligibility groups (mostly individuals and families below Federal Poverty Level) and Optional groups of low-income workers, where incomes may be twice the poverty level – or even higher.

Low-Income Workers:

Category includes some children and pregnant women in working families above the poverty level and working disabled persons. Like their counterparts in the Basic Health program**, some of these clients will be assessed small premiums – ranging from $10 to $20 a month, depending on their income.**



The Most Vulnerable:

Families at or below the Federal Poverty Level would not have to pay premiums or lose any mandatory services, which include hospital care, physician visits, nursing facility, home health care, family planning or any services diagnosed as needed by children.

CHILDREN OF ALL AGES: Low-income children are protected by federal law from any barriers to care, although they may be assigned small co-pays.

PREGNANT WOMEN and NEWBORNS: Low-income pregnant women will be insulated from paying premiums under the waiver.

ELDERLY, BLIND AND DISABLED: Mandatory services would not change, and only certain optional adults would lose vision, hearing and dental services.

REFUGEES, NURSING HOMES: Refugees and people granted asylum by law receive medical care. Also unchanged: The commitment to provide long-term care for the aged and disabled. The waiver would not affect institutional services to the disabled, including both institutional and home- and community-based services.

Federal Poverty Levels

Family Size	Annual Income
1	$ 8,860
2	$11,940
3	$15,020
4	$18,100
5	$21,180

State of Washington
Department of Social and Health Services
Amended Medicaid & SCHIP Reform Waiver Application
July 22, 2002

MEDICAID & SCHIP REFORM WAIVER - WAIVER STATUS

Categories	May 2002 Eligibles				Waiver Provisions			
	Adults	Children [1]	Total	Percent of Total [2]	Copayments	Premiums	Benefit [3]	Enrollment Freeze
Non-Waiver Demonstration Groups								
CN Family Medical	94,659	176,486	271,145	32.6%	X	TMA Revised	Medicaid	
CN Aged	55,455		55,455	6.7%	X		Medicaid	
CN Blind & Disabled	101,187	15,138	116,325	14.0%	X		Medicaid	
CN Optional Breast and Cervical Cancer	91		91	0.0%	X		Medicaid	
CN Pregnant Women	22,488	1,596	24,084	2.9%	X		Medicaid	
CN Mandatory Children		174,176	174,176	20.9%	X		Medicaid	
CN Foster Care & Adoption Support		15,648	15,648	1.9%	X		Medicaid	
CN Family Planning	67,688	13,276	80,964	9.7%	X		FP only	
SLMB Cost-Sharing Only	6,001		6,001	0.7%	X		Medicaid	
Refugee	780	40	820	0.1%	X		Medicaid	
Total	348,349	396,360	744,709	89.5%				
Total less Family Planning	280,661	383,084	663,745	79.7%				
Waiver Demonstration Groups								
CN Optional Children		147,667	147,667	17.7%	X	X	Medicaid	X
CN Optional HWD	50		50	0.0%	X	HWD Revised	Waiver	X
MN Aged	5,839		5,839	0.7%	X	X	Waiver	X
MN Blind & Disabled	8,319	1	8,320	1.0%	X	X	Waiver	X
MN Other	20	34	54	0.0%	X	X	Waiver	X
SCHIP		6,798	6,798	0.8%	X	SCHIP Revised	Medicaid	X
Total	14,228	154,500	168,728	20.3%				
Total Medicaid [2]	362,577	550,860	913,437	109.7%				
Total Medicaid Less Family Planning	294,889	537,584	832,473	100.0%				

NOTES:

[1] Children are persons under age 19.

[2] Percentage is total Medicaid enrollees less family planning enrollees.

[3] Medicaid coverage is the same benefit package received prior to the waiver. Waiver benefit design would be the Medicaid benefit design minus nonemergent dental, vision care and hearing care.